OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Padcev® (Enfortumab Vedotin-ejfv) Prior Authorization Form

SoonerSelect | aetna

Member Name: _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

Drug Information

☐ **Physician billing (HCPCS code:** _____**)** ☐ ❑**Pharmacy billing (NDC:** _____**)**

Dose: _____ ***Regimen:*** _____ ***Start Date (or date of next dose):*** _____

Billing Provider Information

Provider NPI: _____ ***Provider Name:*** _____

Provider Phone: _____ ***Provider Fax:*** _____

Prescriber Information

Prescriber NPI: _____ ***Prescriber Name:*** _____

Prescriber Phone: _____ ***Prescriber Fax:*** _____ ***Specialty:*** _____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:
   - ☐ Locally Advanced or Metastatic Urothelial Cancer
   - ☐ Other: _____
2. Will enfortumab vedotin-ejfv be used as a single agent? Yes☐ No☐
3. Has the member previously received a programmed death 1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor and a platinum-containing chemotherapy in the neoadjuvant/adjuvant, locally advanced, or metastatic setting? Yes☐ No☐
4. Has the member received at least 1 prior therapy? Yes☐ No☐
5. Is the member eligible for cisplatin-containing chemotherapy? Yes☐ No☐
6. Will enfortumab vedotin-ejfv be used in combination with pembrolizumab? Yes☐ No☐

Additional Information: _____

For Continued Authorization:

1. Date of last dose: _____
2. Does member have any evidence of progressive disease while on enfortumab vedotin therapy?
   Yes☐ No☐
3. Has member experienced any adverse drug reactions related to enfortumab vedotin therapy?
   Yes☐ No☐

If yes, please specify adverse reactions: _____

Additional Information: _____

_____

Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Failure to complete this form in full will result in processing delays.*

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**	CONFIDENTIALITY NOTICE *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*